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Clinical Supervision: A Key to Treatment Success

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Intense competition for limited substance abuse program funds, combined with increased scrutiny of program costs and results, has created a need for better understanding of how clinicians, organizations and systems can work together to improve treatment outcomes. While clinical supervision has long been regarded as a significant part of the addiction treatment process, the importance of effective supervision has gained increased attention in this competitive environment. The emphasis on evidence-based practice has also contributed to renewed focus on the supervision process. This article will focus on the elements of effective clinical supervision in addiction treatment and explore the role of the clinical supervisor in an evidence-based practice environment.

Definition of Clinical Supervision

A variety of definitions for clinical supervision exist. Differences typically reflect aspects of the author's discipline and training focus. Bernard and Goodyear (1998) offer this definition that has come to be accepted within the counseling profession:

> *Supervision is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession.*[1]

This definition identifies the participants in the relationship, the quality of the relationship and its purposes. The elements of this definition are present to varying degrees in all models of clinical supervision.

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Models of Supervision

There are significant parallels between the supervision of staff and therapeutic work with clients. In both relationships, one participant is charged with the responsibility of facilitating growth and change in the other participant through focused or structured interactions. There are some critical differences between counseling and supervision. Gallon (2002) has provided the following framework to make the comparison:[2]

DIFFERENCES BETWEEN COUNSELING AND SUPERVISION

	COUNSELING	CLINICAL SUPERVISION	ADMINISTRATIVE SUPERVISION
PURPOSE	Personal growth Behavior changes Decision-making Better self-understanding	Improved job performance	Assure compliance with agency policy and procedure
OUTCOME	Open-ended based on client needs	Enhanced proficiency in knowledge, skills and attitudes essential to effective job performance	Consistent use of approved formats, policies, and procedures.
TIME FRAME	Self-paced; longer-term	Short-term and on-going	Short-term and on-going
AGENDA	Based on client needs	Based on service mission and design	Based on agency needs
BASIC PROCESS	Affective process which includes listening, exploring, teaching	Assessing worker performance, negotiating learning objectives, and teaching/learning specific skills	Clarifying agency expectations, policy and procedures, assuring compliance

In general, models of clinical supervision have been classified by the philosophical framework that underlies the process. Clinical supervision models fall into these four basic categories: psychotherapy-based, developmental, social-role and eclectic.

Developmental models of supervision have dominated supervision thinking and research since the 1980s. Developmental conceptions of supervision are rooted in developmental psychology–the description, explanation and modification of individual behavior across the life span. Such models are based on two basic assumptions:

· In the process of moving toward competence, counselors move through a series of stages that are qualitatively different from one another

· Each supervisee stage requires a qualitatively different supervision environment if optimal supervisee satisfaction and growth are to occur (Chagon and Russell, 1995).[3]

One of the most prominent writers on clinical supervision for the addiction treatment field is Dr. David Powell. Powell (1993) indicates that a model of supervision has a number of layers:

· Philosophical foundation - the theory of change that underlies the counseling approach to be used;

· Descriptive Dimensions - specific characteristics of the counseling and supervision processes;

· Contextual factors - characteristics of client, counselor, supervisor and setting that affect the supervision environment; and

· Stage of development - level of training, knowledge and skill of both supervisor and counselor.[4]

In Powell's view, the focus of supervision is behavioral change and skill acquisition. In other words, the emphasis should be on helping staff learn how to use personal skills and attributes in counseling to promote behavioral change in the client. Powell notes that models of supervision have tended to emphasize either skill development or the emotional/interpersonal dynamics and self-discovery of the worker. In chemical dependency, the emphasis

has been on skill development. However, newer models have incorporated both. Stoltenberg and Delworth (1987) have developed an integrated developmental model for supervision that is used by Powell. In this model, the developmental levels of both counselor and supervisor are viewed with regard to: autonomy, self and other awareness and motivation.[5]

Critical Issues in Supervision

In most addiction treatment agencies, clinical and administrative supervision are performed by the same person. It is important to balance the time spent in supervision between these two elements. A supervisor is very often positioned within the organization between upper management and front-line staff who are implementing organizational programs and policies. This micro-macro balance creates an inherent tension within the demands and expectations of these two organizational layers. The clinical supervisor must negotiate this balance in a way that facilitates both growth in the counselor and effectiveness in the organization.

It is important to consider ethical principles that influence the practice of supervision. The same concerns for appropriate boundaries, maintaining confidentiality and unconditional positive regard that characterize the counseling relationship apply to the relationship between counselor and supervisor. The clinical supervisor must also make a commitment to his or her own growth and skill development within the changing context of the addiction field in order to provide the highest quality of supervision possible.

The clinical supervision process focuses on building particular counselor skills or competencies.

Role of Clinical Supervision in Evidence-Based Practice

Clinical supervision has taken on increasing importance as the addiction field has moved toward evidence-based practice. Often, the clinical supervisor is the critical agent of change within the addiction treatment agency. As a change agent, the clinical supervisor must be familiar with the change process, adept at assessing readiness to change both within the agency and the counselor, and skilled at overcoming resistance. Another part of the supervision challenge is to be an advocate for the counselors (and by extension the clients) by promoting changes in the organization that can facilitate and enhance the work of the counselors. Counselors may have higher levels of satisfaction and be more productive if they feel organizational policies are working for and not against them. This challenge usually falls on the supervisor's shoulders. While managers and administrators often initiate the move toward evidence-based practice within a particular setting, supervisors and counselors are key to understanding which specific evidence-based interventions are timely and relevant for their clients' problems. That means they must provide leadership in the agency on the selection of evidence-based practices that address these needs.

One critical area of supervision in the evidence-based environment is the focus on training. Counselors and supervisors often tend to seek training in small doses of novel treatment models rather than the more intensive dosage needed to fully master a specific evidence-based model. To provide leadership and promote staff development, supervisors must also be well trained in the evidence-based practice (and its conceptual model) that is being implemented and must be able to monitor adherence to that model. The clinical supervisor may be required to supplement initial training with both formal and informal follow-up learning opportunities. In addition, the clinical supervisor may be given the responsibility of monitoring adherence to the evidence-based model to assure fidelity in implementation. This task may be difficult for supervisors whose philosophy of supervision has been more exploratory or insight-oriented, rather than skill-focused. Additional training in supervision for the specific evidence-based practice may be required.

Clinical Supervision: A Key to Treatment Success

The Southern Coast ATTC has identified training in clinical supervision as one of its strategic priorities. In the fall of 2003, we offered a series of three-day courses in clinical supervision in five cities throughout Florida. We are currently developing our training calendar for 2004 and will offer this course again. The ATTC is committed to developing the addiction workforce to respond to the demands of a changing practice environment. Equipping supervisors to fulfill their critical functions within the treatment framework is a key aspect of that development.

References

[1] Bernard & Goodyear, B. (1998). *Fundamentals of Clinical Supervision*. (2nd ed.). Boston: Allyn & Bacon.

[2] Gallon, S. (2002) *Clinical Supervision Training Manual.* Portland, OR: Northwest Frontier ATTC.

[3] Chagon, J., & Russell, R. K. (1995). *Assessment of supervisee developmental level and supervision environment across supervisor experience*. Journal of Counseling and Development. 73, 553-558.

[4] Powell, D. (1993). *Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models and Methods*. New York: Lexington Books.

[5] Stoltenberg, C. D., & Delworth, U. (1987) *Supervising counselors and therapists*. San Francisco, CA: Jossey-Bass.

RESOURCES FOR CLINICAL SUPERVISION

Arrasmith, D. and Gallon, S. L., (2001). *Performance Assessment Rubrics for the Addiction Counseling Competencies.* Salem, Oregon: Northwest Frontier Addiction Technology Transfer Center.

Center for Substance Abuse Treatment (1998) *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice.*

Gallon, S. (2002) *Clinical Supervision Training Manual*. Portland, OR: Northwest Frontier ATTC.

Information about distance education in addictions: www.nattc.org/addictionEd/index.asp

Online course in Clinical Supervision using Powell's text: www.dlcas.com

Powell, D. (1993). *Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models and Methods.* New York: Lexington Books

Stoltenberg, C.D. & Delworth, Uc. (1987). *Supervising Counselors and Therapists.* San Francisco: Jossey-Bass.

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